psoriasis that has been resistant to conventional therapy, PUVA treatment may be administered according to established guidelines with proper precautions taken to minimize potential toxicity to the skin and eyes.

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ANA-Negative Systemic Lupus Erythematosus

THE PRESENCE OF antinuclear antibodies (ANA) is generally held to be an important criterion in the diagnosis of systemic lupus erythematosus (SLE). However, careful reading of the literature shows a well-described but generally neglected small group of patients with clinical SLE and negative ANA reactions.

In 1978 Fessel reported on ten patients (whose cases had been followed for ten years) with clinical signs of disease but persistently negative reactions to ANA. Each of the ten met at least four of the American Rheumatism Association (ARA) criteria for diagnosis of systemic lupus erythematosus. He noted that Raynaud phenomenon, loss of hair and ulcers of the mouth were more common in ANA-negative patients. It is noteworthy that these signs are all unlikely to be caused by immune complex deposition. However, only one of the ten patients had kidney involvement.

Other studies show similar findings. Pollak in 1964 obtained negative results in 9 patients among 112 with SLE. He summarized the results previously reported in seven other studies containing a total of 274 patients. He noted 7 percent of patients with negative tests for ANA. In the same year, Leonhardt reported that 3 of his 71 patients with SLE had negative tests for ANA. In 1968 Zeiman and co-workers reported clinicopathologic correlation in patients with lupus nephritis; 7 percent of their 28 patients had persistently negative tests for ANA. Estes and Christian obtained negative results in 13 percent of their 150 patients. In 1974 Bartholomew observed that 5 of 121 patients had negative ANA. In 1977 Lee and co-workers noted 5 patients with negative ANA among 110 patients followed for up to five years.

ANA-negative systemic lupus erythematosus seems to be a subgroup of SLE that has not previously been given adequate attention. Raynaud phenomenon, excessive loss of hair and ulcers of the mouth are frequent in this subgroup and the patients are noted to have had prolonged survival. Whether the ANA reaction is negative because of absent production of ANA, because of their in vivo binding by tissues or because of their being hidden in circulating immune complexes, warrants further study. In the meantime, it is important that clinicians be aware that approximately 5 percent of patients with SLE may have persistently negative tests for ANA.

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New Pustular Dermatoses of Infants

TWO NEW FORMS of cutaneous eruptions with unknown causes have been described recently in infants.

Infantile acropustulosis is an uncommon syndrome that consists of recurrent crops of pruritic papulopustules and papulovesicles 1 to 2 mm in size occurring on the distal extremities. Although this dermatosis may be present in infants at birth, it generally begins between the ages of 2 and 10 months, and may persist for two to three years before spontaneous remission occurs. This condition predominates in black infants, and there is no family history of atopy or psoriasis.

The primary lesion is a pinpoint erythematous papule which enlarges to a well-circumscribed and discrete pustule or vesicle within 24 hours. There is no tendency to coalesce. New crops of intensely pruritic vesicopustules appear for a week to ten days, then remit for an interval of two to three weeks before recurring. Most of the lesions are distributed on the palms and soles, with lesser numbers on the dorsa of the hands, wrists, feet and ankles. The eruption is said to be worse in the summer.

Histological examination of infantile acropustulosis shows nonspecific subcorneal or intraepidermal vesicles and pustules which are filled with neutrophilic polymorphonuclear leukocytes and rare eosinophils. Results of routine laboratory